

WELL CHILD 9 - 10 - 11 - 12 YEARS					Name: _____ <input type="checkbox"/> Female <input type="checkbox"/> Male	
Visit Date: ___/___/___			DOB: ___/___/___		Age: _____ Grade: _____	
Language spoken: <input type="checkbox"/> English Other: _____				<input type="checkbox"/> Interpreter used – Name: _____		
BP: _____	T: _____	P: _____	R: _____	Height: _____	Weight: _____	BMI%: _____ <input type="checkbox"/> Growth charts completed
Reason for visit: _____						
Allergies: _____				Signature/ Title: _____		

INTERVAL HISTORY accompanied by:		EDUCATION / ANTICIPATORY GUIDANCE: <i>Check if discussed</i>				
Diet: _____	Appetite: _____	Diet and Exercise	<input type="checkbox"/> food choices/caloric balance <input type="checkbox"/> appropriate weight			
Weight - significant <input type="checkbox"/> loss <input type="checkbox"/> gain # lbs.: _____			<input type="checkbox"/> body image <input type="checkbox"/> eating disorders <input type="checkbox"/> physical activity			
Physical Activity: _____		Safety	<input type="checkbox"/> abuse/strangers/911 <input type="checkbox"/> anger management			
Seeing dentist: <input type="checkbox"/> Yes <input type="checkbox"/> No TB risk: <input type="checkbox"/> No <input type="checkbox"/> Yes			<input type="checkbox"/> risky behaviors <input type="checkbox"/> safety helmet <input type="checkbox"/> seat belt use			
Medications / Vitamins: _____		High risk behavior	<input type="checkbox"/> smoking <input type="checkbox"/> alcohol, drugs			
Females – Menarche age: _____ LMP: ___/___/___			<input type="checkbox"/> sexual activity (condoms, contraception, STD risk)			
Sexually active: <input type="checkbox"/> no <input type="checkbox"/> yes – contraception type: _____		Guidance	<input type="checkbox"/> depression <input type="checkbox"/> family dynamics <input type="checkbox"/> future goals			
Tobacco - <input type="checkbox"/> smoke exposure <input type="checkbox"/> use			<input type="checkbox"/> independence <input type="checkbox"/> privacy <input type="checkbox"/> puberty progress			
Alcohol: <input type="checkbox"/> No <input type="checkbox"/> Yes			<input type="checkbox"/> social interaction <input type="checkbox"/> sun screen			
Drugs: <input type="checkbox"/> No <input type="checkbox"/> Yes		Comments: _____				

IMMUNIZATIONS up to date: Yes No – needs: _____

Illnesses, accidents, fatigue, nightmares: _____

DEVELOPMENT/SCHOOL PROGRESS - *Achievement, school attendance, sports, hobbies, peer relationships*

PARENTAL/PATIENT CONCERNS:

PHYSICAL EXAMINATION – *note required for all not WNL*

General Appearance	<input type="checkbox"/> well nourished and developed	Lungs	<input type="checkbox"/> clear to auscultation bilaterally
	<input type="checkbox"/> no abuse/neglect evident	Heart	<input type="checkbox"/> regular rhythm <input type="checkbox"/> no murmur
Head	<input type="checkbox"/> grossly normal	Femoral pulses	<input type="checkbox"/> normal bilaterally
Eyes	<input type="checkbox"/> PERRL <input type="checkbox"/> vision grossly normal	Abdomen	<input type="checkbox"/> soft, no masses <input type="checkbox"/> liver & spleen normal
Ears	<input type="checkbox"/> canals clear <input type="checkbox"/> TMs normal	Genitalia	<input type="checkbox"/> grossly normal - Tanner stage I II III IV V
	<input type="checkbox"/> hearing grossly normal	Spine	<input type="checkbox"/> no scoliosis
Nose	<input type="checkbox"/> passages clear <input type="checkbox"/> MM pink, no lesions	Extremities	<input type="checkbox"/> no deformities, full ROM
Teeth	<input type="checkbox"/> good dentition <input type="checkbox"/> no caries evident	Skin	<input type="checkbox"/> clear, no significant lesions
Neck	<input type="checkbox"/> supple <input type="checkbox"/> thyroid not enlarged	Neurologic	<input type="checkbox"/> no gross sensory or motor deficit
Chest	<input type="checkbox"/> symmetrical	Comments: _____	
Breasts (F)	<input type="checkbox"/> no masses, Tanner stage I II III IV V	_____	

ASSESSMENT:	VISION	Near	OD: _____	OS: _____	OU: _____
		Far	OD: _____	OS: _____	OU: _____
	AUDIO - metry	Right	_____ dB	_____ Hz	<input type="checkbox"/> WNL
		Left	_____ dB	_____ Hz	<input type="checkbox"/> WNL

PLAN: _____

Performed by: _____

ORDERS: Vaccine reactions, risks and follow-up explained /VIS sheets given Immunization registry entry

Immunizations if not up to date: Td (9yrs) Tdap (11-12 yrs) MCV4 @ 11-12 years Hgb. Urinalysis HIV test Lipid profile

HPV Influenza (yearly) GC, Chlamydia, VDRL (if sexually active)

Screening (objective 9, 10, 12 yrs) Vision Audiometry **Prevention:** Rx for fluoride 0.5/ 1 mg daily (until age 14)

Other: _____

REFERRAL: Dental OB/Gyn Behavioral Health Other: _____

Next appointment: 1 year or _____ **Provider Signature:** _____